REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

While Connecticut should consider the implications and opportunities presented by joining a regional Exchange you should also consider whether or not a Connecticut only or Regional Exchange will best meet the needs of your residents. While a Regional Exchange may allow for the sharing of the overall start up costs and administrative process the nuances of your residents should be a primary driver in the overall evaluation to ensure that they are not sacrificed over the needs to other states participating in the Regional Exchange.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

While the overall administration can be accomplished under one Exchange, the actual processes and risk pools should remain separate. There are unique administrative, service and insurance needs represented by both the individual and small group markets that can only be accommodated through separate processes and risk pools.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

We feel that initially Connecticut as well as other states should continue with the existing definition of small group employers with expansion to the larger end of the small group market in 2016. This will allow the states to ensure a smooth administration, allow time to streamline the Exchange administrative process, rating process, risk pool administration, etc with a subset of the population that will eventually be eligible thus making it more manageable before broadening the scope of the Exchange.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?

We do not feel that the Exchanges should be expanded to include employers with more than 100 employees. The underlying market needs driving the legislation for the Exchanges are represented by the Individual and Small Group employers who can struggle to secure reasonably priced health insurance coverage. While larger employers face issues relative to healthcare coverage access and affordability of that care are generally less of a concern than they are for individuals or small employers.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

We feel strongly that a dual market should continue to exist allowing Plans to either participate on the Exchange and/or off the Exchange. This will ensure that a robust marketplace continues to attract Plans and offers variety of insurance options to the residents of the state. The existing state insurance laws along with the alignment of the Exchange management with those principles should provide adequate guidance to Plans for balanced participation either on or off the Exchange.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

Ensuring that there is a level playing field for Plan participation both on and off the Exchange will help mitigate the risks associated with adverse selection. In addition, an effective risk adjustment mechanism and reinsurance program may help alleviate adverse selection within an Exchange.

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

The temporary reinsurance program should be constructed in such a way that it appropriately identifies and captures all high risk individuals and seeks to align reinsurance payments with the underlying risk. Any reinsurance program should also ensure that carriers continue to have an incentive to control costs and manage quality of care for these individuals. Lastly, any reinsurance program must be simple to administer for carriers in order to ensure that administrative costs can be kept low.

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

In the establishment of the Navigator program Connecticut should be sure to select agencies, groups or organizations that have a detailed familiarity with the insurance industry as well as access to certain populations within the state. The knowledge and understanding of the industry will allow the navigator function to not only direct but to provide sound guidance and direction to those seeking to purchase coverage through the Exchange.

2. What should Connecticut consider regarding the role of insurance brokers and agents?

The brokers and consultants should continue to play a vital role in assisting individuals and small businesses navigate, negotiate and understand the range of opportunity and products available to meet their specific needs. Connecticut should consider promoting these valuable services as yet another avenue for individuals or small employers to evaluate and choose a healthcare plan that will meet their unique needs.

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?

We feel strongly that existing state regulations should be the sole source of evaluation for a state in determining whether or not a plan meets the QHBP standard. We would rather see existing state regulations enhanced to meet the Federal Standards than new standards and yet another administrative approval process be created to evaluate plan eligibility.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?

Given the relatively small pool of individuals that will be eligible for the exchange, the state should carefully consider the potential unintended consequence of creating a Basic Health Program. The Basic Health Program has the potential to reduce the eligible individuals from the exchange pool, reducing the state's ability to equalize costs and bear risk across the largest available risk pool. By allowing all individuals access to the exchange, the state will achieve greater efficiency by spreading fixed administrative costs among more exchange participants. Additionally, allowing those individuals to shop through the exchange will allow the consumer to choose from multiple carriers offering various benefit packages.

3. How would the Basic Health Program impact other related programs in Connecticut?

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

We think that the state should get the exchange for the private market up and running successfully and then examine ways to maximize continuity of coverage between public and private coverage.

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

Connecticut should consider a variety of alternate sources for distribution of key materials advertising the upcoming changes related to the establishment of the State Exchange. Vehicles should include but not be limited to advertising on television, radio, in local newspapers, town hall meetings as well as mobile media. Information included in the outreach should include but not be limited to pertinent dates, key information that individuals and small business need to pay attention to relative to the legislation including when information on plans and offerings will be accessible, enrollment dates, vehicles to evaluate offerings, etc.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

Connecticut should consider the use of an online survey for individuals or small employers evaluating or purchasing coverage through the Exchange. Additionally the use of an post customer service call should be considered to allow immediate feedback from constituents relative to their experience with the Exchange.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

Plans should be required to provide consistent information relative to the basic and additional offerings they market on the Exchange. The information should allow the consumer to make an educated and comparative decision about the plans they are evaluating and purchasing while not providing so much information that the average consumer becomes overwhelmed with the selection process.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?

We encourage Connecticut to look for broad funding sources to support the operation of the Exchanges. Fees to individuals or small businesses as well as Healthplans participating on the Exchanges should be considered as revenue sources. However while fees to participating healthplans should not be ruled out if they are nominal they cannot be the only source of funding as they would have the potential to discourage plans from participating on the Exchanges.

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

Please see the response to the question above.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

Connecticut will have to weigh the criticality of adding any additional benefit requirements mandated through the legislation while balancing the needs of the population and the cost of coverage. Any benefit offerings above the minimum required should be at the expense of the individual purchasing the "richer" benefit plan.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

Initially the Exchanges should focus on the minimum requirements to ensure that the Exchange is up and running within the required timeframe. The establishment of the Exchanges is a huge undertaking for the state and ensuring that the Exchange opens on time, is able to deliver a positive experience for consumers and run efficiently demand a narrower scope initially with potential expansion considered once the Exchange has been running for a period of time.

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

The state Exchanges should consider any Plan operating and licensed in their state today who is in good standing as a QHBP for participation in the Exchange. We support an open marketplace allowing Plans to participate where and when they are able to contribute and provide beneficial offerings for the residents in the State of Connecticut.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?

We would strong encourage Connecticut to survey the smaller employers in the state to determine what if any parameters should be place on this group relative to Exchange participation. The survey would allow the state to determine the needs of small employers in the state as well as ensuring adequate participation to create a balance risk pool in the Exchange and off.

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?

Please see response above

5. What should be the role of the Exchange in premium collection and billing?

The Exchange should be responsible for determining the eligibility of individuals for the Federal Premium Assistance Tax Credit however the actual premium collection and billing for individuals once they chose a plan should be handled by the respective plan thus eliminating a level of complexity and tracking for these funds.

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

The posting of annual budgets, operating expense reports, participation rates and demographics as well as meeting notes, Exchange operational reports should be posted on the Exchange website to provide for full transparency on the Exchanges operation and functions.

BACKGROUND by TOPIC AREA

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.

- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits